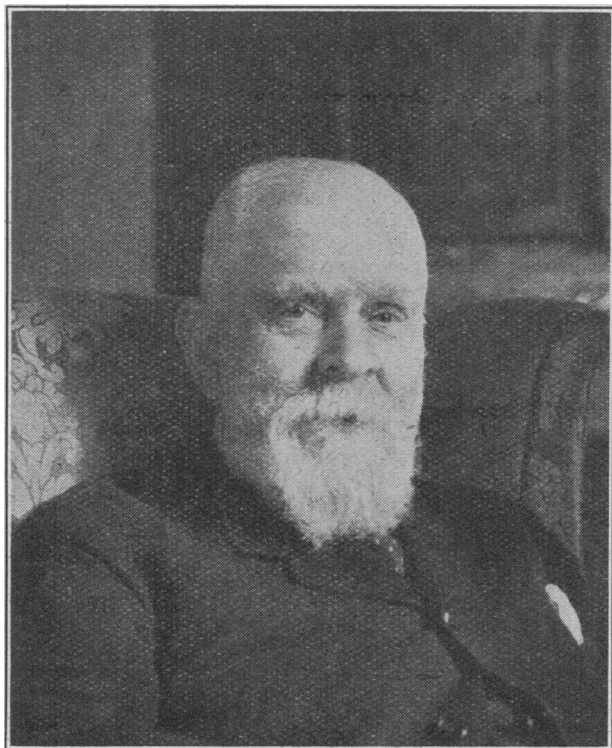


ONE HUNDRED YEARS OLD

All members of the British Medical Association will wish to join in congratulating Dr. Edwin Clifford Beale, who celebrated his 100th birthday last Tuesday. Not only is he the oldest member of the Association, but he has been a Fellow of the Royal College of Physicians longer than any other living person.

The son of Mr. W. J. Beale, who was a solicitor in Edgbaston, Clifford Beale was born in Birmingham on October 16, 1851. From Harrow School, which he left in 1869, he went up to Caius College, Cambridge, and continued his medical education at Guy's Hospital, where he qualified in 1878. After holding posts at Guy's, and visiting



Dr. Clifford Beale

several Continental clinics, he returned to consulting practice in London, being appointed to the staff of the City of London Hospital for Diseases of the Chest (Victoria Park) and of the Great Northern Central Hospital (now the Royal Northern Hospital). He has been a consulting physician to both hospitals for about 45 years.

Dr. Beale became a Member of the Royal College of Physicians in 1881 and a Fellow in 1890. With Sir Clifford Allbutt he was responsible for the revision of the section on diseases of the circulatory system in the fourth edition of the *Nomenclature of Disease*, published by the Royal College of Physicians in 1906. Most of the papers he contributed to medical journals were on subjects connected with his specialty—diseases of the lungs and air passages. An original member of the Laryngological Society, he was its honorary treasurer from 1899 to 1901. In collaboration with Dr. V. D. Harris he wrote a text-book entitled *The Treatment of Pulmonary Consumption: A Practical Manual*; this was published in 1895.

Among those who were working to reform the hospital service in the early years of this century, Dr. Clifford Beale had a prominent place. He contributed an article on "General Hospitals and the Provident System" to a special hospitals number of the *Journal* (June 20, 1908), for which Sir William Osler also wrote a paper. Dr. Beale's contention was that until some substantial advantage could be

offered to the average out-patient to induce him to join a provident dispensary he was not likely to join one. He noted that though one or two hospitals required out-patients to pay a few pence towards the cost of his medicine or dressings the authorities of most hospitals were averse to any system of payment. His plan was to establish a provident branch—to be officered by local practitioners—as part of the out-patient department of every large general hospital: patients would thus secure adequate investigation, would no longer be open to the suspicion of abusing the benefits of charity, and at the same time would secure continuity of treatment. The hospital contributory schemes which later developed so rapidly had many resemblances to Dr. Beale's plan.

One may well wonder whether the newly qualified doctor of to-day who attains his century will see such revolutionary changes in medical practice—and indeed in everyday life—as those Dr. Beale has witnessed during his long and distinguished career.

RECENT ADVANCES IN ENDOCRINOLOGY

LECTURE TO HARVEIAN SOCIETY

At a meeting of the Harveian Society on October 11, with Mr. W. E. TUCKER presiding, the opening paper was given by Dr. S. LEONARD SIMPSON on "Recent Advances in Endocrinology."

Dr. Simpson said that although recent advances in this field had largely depended on biochemical research it would be a mistake to ignore the importance of new clinical observations and the interpretation of older clinical observations in the light of new knowledge.

Pituitary growth hormone had been separated from other pituitary hormones and shown to have an important influence on diabetes, adiposity, and even infection. In rats and puppies it produced somatic growth, nitrogen retention, and increased metabolism of fat, whereas in dogs and cats it was more powerfully diabetogenic than adrenocorticotrophic hormone (A.C.T.H.) (Young, Cotes, and colleagues). The fact that chemists had found it difficult to separate the pituitary growth and the adrenotrophic hormones was not without clinical significance. Hirsutism was not infrequent in acromegalic females; and in one hirsute woman adrenal hyperfunction and hypertrophy of the opposite gland persisted ten years after an androgenic adrenal tumour had been removed. Lynch's case of a tall boy aged 6, with pseudo-sexual precocity, who had an adrenal tumour removed, and several years later was still excessively tall and precociously hirsute, also suggested the possibility of a pituitary stimulus to adrenal neoplasia as well as hyperplasia.

Dr. Simpson referred to the clinical importance of Kendall's experiments on the effect of adrenal glucocorticosteroids on body composition in mice. Though Compound A increased total weight and Compound B decreased total weight, in both cases the percentage of fat in relationship to protein was increased, indicating a qualitative effect of hormones on fat deposition. The hypothesis had been put forward that glucose derived from protein breakdown was converted into fat in the presence of these adrenal compounds. Growth hormone produced an increased proportion of body protein rather than of fat in contrast with the action of A.C.T.H. Pancreatic islet carcinoma was the only carcinoma in which the presence of metastases was manifested by increased weight and fat deposition. Did a hypothalamic lesion produce adiposity metabolically apart from simple polyphagia? Some women increased their weight considerably during pregnancy and then returned to normal or near normal. Was this a manifestation of pituitary-adrenal hyperfunction and its subsequent involution?

Therapeutic Use of Cortisone and A.C.T.H.

In Addison's disease, desoxycortone still remained the basis of treatment, but additional cortisone by mouth in small doses—e.g., 4-8 mg. three times daily—was proving

helpful where the patient failed to gain weight, where there was a tendency to hypoglycaemia, and where fatigability and irritability persisted. Larger doses might be required in a crisis, but should not be given for long periods, as there was a danger of spread of coexisting tuberculous lesions. The use of A.C.T.H. was irrational in Addison's disease, as the destroyed adrenal cortex was incapable of responding. In contrast, A.C.T.H. was useful in Simmonds's disease, although he believed the basic and more convenient treatment was methyl testosterone supplemented where necessary by thyroid and small or medium doses of cortisone. Pure growth hormone would probably prove more potent as a hypoglycaemic agent than cortisone.

Cortisone and A.C.T.H. had been used therapeutically in a wide variety of non-endocrine disorders. In general, he felt their use would tend to be restricted in the course of time to those conditions where the smaller physiological doses were effective over a long period, where the great need was for amelioration of an acute exacerbation of disease that threatened life, or where small doses locally applied could prove an effective aid to therapy—e.g., in a variety of ophthalmic conditions. Both hormones had an important influence on allergic states, and, apart from their intrinsic usefulness in this field, their action drew attention to the older theories of the allergic manifestations of some diseases. As to rheumatoid arthritis, he believed that experience was showing that these hormones could not be effective in the more severe varieties of this disorder without producing the adverse hormone effects that might be expected from large doses over long periods. As others had done, he had met with Cushing's syndrome in rheumatoid arthritis, produced by cortisone, with the complication of severe osteoporosis of the spine and compression fracture. It was also recognized that cortisone could produce abnormal behaviour patterns and psychopathic states. Both A.C.T.H. and cortisone might be very valuable in minimizing some distressing manifestations of the body's reaction to disease, even though they did not necessarily affect the course of the disease process. It must also be recognized that, experimentally and clinically, cortisone appeared to inhibit the localization of disease and caused its spread—e.g., in tuberculosis and actinomycosis, as well as in streptococcal infections. Nevertheless the body did react to infection by a secretion of cortisone, and the conditions and measurements of such a reaction deserved study in an attempt to determine in what direction and in what dosage the body could be helped or hindered.

SOVIET MEDICINE

IMPRESSIONS OF THREE BRITISH DOCTORS

Three British doctors who have recently visited Soviet Russia gave their impressions at a medical meeting on September 27, arranged by the Society for Cultural Relations with the U.S.S.R.

Dr. IAN GILLILAND said that the Russian medical services were predominantly preventive. The medical examination of the population was carried out in the most elaborate way. Much emphasis was placed on health education, starting with the children. Health centres were universally provided. Here the patient came into contact, not with an individual doctor, but with a team of people, including those who in this country would be called public health and industrial medical officers. The preparation for medicine took six years, and part of the time was spent in hospital and part in the health centre (general practice). In showing some lantern slides of modern Moscow, he drew attention to the central block of the university, which was to be opened in December. Single rooms were to be provided for 6,000 students. Night life in Moscow was light-hearted but wholesome; there was no prostitution, and the doctors were confident that they were going to abolish venereal disease—and he felt sure they would.

The Russian Health Centre

Dr. HORACE JOULES said that his visit was the most stimulating three weeks he had ever spent. He was impressed especially by the health centres, which were probably far ahead of the hospitals; but between the two institutions there was an increasingly close relationship. Each health-centre doctor and each doctor working in the school health service spent half of his or her time in hospital. It was claimed that since 1947, thanks to this close relationship and the consequent upgrading of the general practitioner, the differences in diagnoses made at health centre and hospital had been reduced from 25% to 10%. There was no lack of doctors in Russia; doctors were waiting for patients rather than the other way round, and the doctor's day was 6½ hours. The equipment of health centres was extremely good. Many of these centres had electrocardiographic apparatus, and all those that he saw had quite modern x-ray installations.

The Deputy Minister of Health had assured the party that there were 15 hospital beds per 1,000 population, and that this held for both town and country. There was no hurry to discharge patients; the average stay of a case of coronary thrombosis was 12 weeks. There were no waiting-lists at the hospitals of Moscow, Stalingrad, or Tashkent. The hospitals were administered by elected people and financed nationally. A medical administrator was in charge of each hospital: a co-ordinator rather than a dictator. There was one trade union for all health workers; membership was voluntary but almost universal, because it carried privileges. The individual comfort of patients was not quite as well attended to as in our own best hospitals; equipment did not give the same idea of near-luxury, but provision was more than adequate. He saw no ward with more than fourteen beds; the majority had not more than six, and there was more day-room accommodation than was customary here. The provision of nursing staff was not exceeded even in our own teaching hospitals. In a 2,200-bed hospital in Moscow there were 900 trained nurses and 600 in training. Nurses worked a six-hour day; those on night duty did 12 hours and then had two nights free. They had a training comparable with that of British nurses, but with less emphasis on the academic side. In Moscow accident cases were directed to three main hospitals, each with a first-class traumatic service. Finally, Dr. Joules spoke of the anti-tuberculosis campaign. Mass radiography was practised on an immense scale, and in the age groups 17–40 the Russians were attempting to ensure a yearly examination.

Infant Welfare

Dr. MARY BARBER, who had more recently returned from Moscow than the others, described children's hospitals and maternity provision. Even in Stalingrad, which had had to undertake a vast rebuilding plan, there were enough maternity beds for all women to have their babies in hospital. In the children's hospitals teachers were employed for such of the children as were able to benefit educationally during their stay. She had visited also some of the epidemiological stations. These were concerned not only with combating infectious diseases, but with all that had to do with the social life and work of the people. There was one such station in each of the 25 districts of Moscow. The bacteriological laboratories were closely occupied with investigations for possible diphtheria and dysentery carriers among the general population. She noted in the lecture theatres portraits of Pasteur, Lister, and Koch as well as of Pavlov and Metchnikov. Russia was making large amounts of penicillin and streptomycin as well as a variant of chloramphenicol. With regard to vaccination and immunization, she understood that in the Soviet Union no prophylactic injections were compulsory by law, but it was recommended that all babies should be vaccinated against smallpox and diphtheria, and the doctors said that everybody accepted vaccination. In reply to her remark that there must be some who objected, she was told, "There are no such backward people in this country." The B.C.G. vaccine was used